

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1339

CERTIFICATE OF DEATH

01293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McCoole-Rural</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Robert</u> Last <u>Ahern</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 28, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>Machinist helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile Plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Westernport, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Ahern</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-07-5756</u>	
17. INFORMANT <u>Mrs. Eva Ahern, McCoole, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis Generalized</u> 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Liver -</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1 -</u> , 19 <u>57</u> , to <u>Feb 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 2</u> , 19 <u>57</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>2-4-57</u>			
ACTUAL SIGNATURE <u>T.C.G. + Fin</u> M.D. <u>Rever Mr</u>		PHYSICIAN'S NAME (Type) <u>T.C.G. + Fin</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/5/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>El Gwal</u>		ADDRESS <u>Westernport, Md.</u>	
24a. REC'D BY REGISTRAR <u>2-5-57</u>		24b. REGISTRAR'S SIGNATURE <u>John C Kelly</u>	

RECEIVED
FEB 7 1957
BUREAU V. S.

CERTIFICATE OF DEATH

1957

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1340

CERTIFICATE OF DEATH

01294

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bedford Rd #3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD #3, Bedford Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lloyd</u> Middle <u>Richard</u> Last <u>Ambrose</u>		4. DATE OF DEATH <u>Feb</u> Month <u>24</u> Day <u>1957</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 18, 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Bookmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Crestview N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard E. Ambrose</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Willard Ambrose</u>		Address <u>Cum. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of abdominal aorta</u> 451X DUE TO <u>gastrovascular arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>15 minutes</u> (c) <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Monday, 19 57</u> to <u>2-24 57</u> , that I last saw the deceased alive on <u>2-23-57</u> , and that death occurred at <u>9:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. T. Johnson Jr.</u>		DATE SIGNED <u>2-25-57</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T. JOHNSON, JR., M.D.</u>		ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 27, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		24. REC'D BY REGISTRAR <u>W. R. Parry, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957

See Instructions

<p>1. NAME OF DECEASED <i>Michael E. Smith</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>35</i></p>		<p>4. DATE OF BIRTH <i>1922</i></p>	
<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>1945</i></p>	
<p>9. NAME OF SPOUSE <i>Elizabeth A. Smith</i></p>		<p>10. DATE OF DEATH <i>Feb 28 1957</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>[Signature]</i></p>		<p>16. OFFICIAL USE</p>	

BUREAU V. 3

FEB 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01295

1329

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport				c. LENGTH OF STAY IN 1b 88 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kookon Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Bothwell Last Bothwell				4. DATE OF DEATH Month Feb. Day 14 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 27, 1861	
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY OTP Rail Road		11. BIRTHPLACE (State or foreign country) Scotland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME William Bothwell				14. MOTHER'S MAIDEN NAME Elizabeth Archibald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Laura Bothwell Mc-Kenzie, Westernport				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration not specified as Rheumatic DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 Years 10 Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Feb. 7, 1957 , to Feb. 14, 1957 , that I last saw the deceased alive on Feb. 13, 1957 , and that death occurred at 8:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont, W. Va. DATE SIGNED Feb. 15, 1957							
ACTUAL SIGNATURE Paul R. Wilson M.D.				PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Philos Cem.	
22d. LOCATION (City, town, or county) Westernport				(State) Ma.			
23. FUNERAL DIRECTOR'S SIGNATURE E. J. S. S. S.				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 2-16-57	
24b. REGISTRAR'S SIGNATURE Jean C. Kelly							

BUREAU V. 8

FEB 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4: may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1284

CERTIFICATE OF DEATH

01296

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>829 Shiver Ave</u>		d. STREET ADDRESS <u>829 Shiver Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William L Brendlinger</u>		4. DATE OF DEATH <u>Feb. 5, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 10, 1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired News Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Evening Times & News</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. E. Brendlinger</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Raymond</u>		Address <u>Cumb. MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetic Mellitus</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>2-5, 1957</u> that I last saw the deceased alive on <u>2-1-1957</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. T. Johnson, Jr.</u>		M.D. <u>Cumberland, Md</u> DATE SIGNED <u>2-7-57</u>	
PHYSICIAN'S NAME (Type) <u>James T. Johnson, Jr., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 7, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Paul Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u>		ADDRESS <u>Cumberland MD</u>	
24a. REC'D BY REGISTRAR <u>Feb. 7, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Grantz, Md.</u>	

CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		RECEIVED		RECEIVED		RECEIVED	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION	
RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH	
COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH	
SIGNATURE		SIGNATURE		SIGNATURE		SIGNATURE		SIGNATURE		SIGNATURE		SIGNATURE		SIGNATURE	
DATE		DATE		DATE		DATE		DATE		DATE		DATE		DATE	

BUREAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01297

Reg. Dist. No.

1285

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Sacred Heart Hospital		e. STREET ADDRESS 122 S. Lee St. Cumberland, Md	
3. NAME OF DECEASED (Type or print) First George Middle M. Last Brown		4. DATE OF DEATH Month Feb. Day 10 Year 19 57	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31-1891
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 10 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Southern Bar	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Brown		14. MOTHER'S MAIDEN NAME Agnes Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 219-14-6085	
17. INFORMANT James Brown, Cumberland, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 892.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Carbon monoxide poisoning. (c) Hole in chimney where vent pipe entered, stuffed with paper & paper. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) up.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Closed bathroom, gas heater on, no chimney vent, stuffed	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) up.		20c. TIME OF INJURY Month, Day, Year 7 - 10 - Feb. 10 1957 Hour 7 o. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Cumberland		(County) Allegany	
(State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Feb. 10-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 13, 1957	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) Cumberland, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.		24a. REC'D BY REGISTRAR Feb. 12, 1957	
24b. REGISTRAR'S SIGNATURE W.R. Trantz, M.D.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

01837

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to fading and bleed-through from the reverse side.

BUREAU V. 2

1957

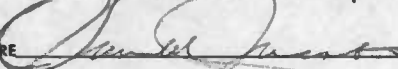
RECEIVED

1286

CERTIFICATE OF DEATH

01298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 1 101 IAING AVE.	
3. NAME OF DECEASED (Type or print) First TILDEN Middle S. Last BURNS		4. DATE OF DEATH Month FEBRUARY Day 17 Year 1957.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH OCT. ? 1876
9. AGE (In years lost birthday) yrs. 80		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B. & O. RAILROAD		10b. KIND OF BUSINESS OR INDUSTRY Machinist	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB C. BURNS		14. MOTHER'S MAIDEN NAME MARY GAVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-09-988	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial decompensation and failure DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Myocardial fibrosis, Coronary arteriosclerosis (c) Auricular fibrillation			INTERVAL BETWEEN ONSET AND DEATH 4 days ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anuria			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February 16 1957 , to February 17, 1957 , that I last saw the deceased alive on February 17 1957 , and that death occurred at 6:28P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 50 Pershing St., Cumberland, Md. 2-19-57			
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) DR. S. M. JACOBSON	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-20-57	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24. REG'D BY REGISTRAR Feb 20, 1957	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

NAME JAMES C. DUNN		SEX Male		DATE OF BIRTH OCT 2 1898		PLACE OF BIRTH BALTIMORE, MARYLAND	
OCCUPATION LABORER		MARITAL STATUS Single		COLOR White		HEIGHT 5' 10"	
WEIGHT 160 LBS		BUILD Medium		EYES Blue		HAIR Brown	
DEATH FEB 25 1938		PLACE BALTIMORE, MARYLAND		CAUSE Myocardial Infarction		MANNER Natural	
SIGNATURE OF PHYSICIAN J. C. DUNN		SIGNATURE OF DEATH REGISTRAR J. C. DUNN		SIGNATURE OF WITNESS J. C. DUNN		SIGNATURE OF WITNESS J. C. DUNN	

RECEIVED
 FEB 25 1938
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01299

1330

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH o. COUNTY A llegalany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 116 Center St.				d. STREET ADDRESS 116 Center St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle T. Last COMER				4. DATE OF DEATH Month Feb. Day 6 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-16-1866	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 90 Days 90 Hours 90 Min.		IF UNDER 24 HRS. Months 90 Days 90 Hours 90 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired miner				10b. KIND OF BUSINESS OR INDUSTRY coal mines		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward Comer				14. MOTHER'S MAIDEN NAME Bridget Connor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none				16. SOCIAL SECURITY NO. none			
17. INFORMANT Miss Anna Comer, Frostburg, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis (c) Arterio Sclerosis				INTERVAL BETWEEN ONSET AND DEATH 6 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1950 , 19 50 , to Feb 6 , 19 57 , that I last saw the deceased alive on Feb 6 , 19 57 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm C Lane M.D.				ADDRESS (Street, city or town, state) Frostburg			
PHYSICIAN'S NAME (Type) Wm C Lane MD				DATE SIGNED Feb 5 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-9-1957		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR DATE 2-9-57		24b. REGISTRAR'S SIGNATURE Mr. James N. Rose	

RECEIVED

FEB 18 1957

BUREAU V. 2

STATE OF MARYLAND DEPARTMENT OF HEALTH-PATROLOR 10		1957	
CERTIFICATE OF DEATH			
DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CORONER		SIGNATURE OF JUDGE	
SIGNATURE OF CLERK		SIGNATURE OF NOTARY	
SIGNATURE OF CHURCH		SIGNATURE OF SCHOOL	
SIGNATURE OF EMPLOYER		SIGNATURE OF NEAREST RELATIVE	
SIGNATURE OF FRIEND		SIGNATURE OF MINISTER	
SIGNATURE OF RABBI		SIGNATURE OF PRIEST	
SIGNATURE OF BISHOP		SIGNATURE OF ARCHBISHOP	
SIGNATURE OF CARDINAL		SIGNATURE OF POPE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	
SIGNATURE OF CHURCH		SIGNATURE OF SCHOOL	
SIGNATURE OF EMPLOYER		SIGNATURE OF NEAREST RELATIVE	
SIGNATURE OF FRIEND		SIGNATURE OF MINISTER	
SIGNATURE OF RABBI		SIGNATURE OF PRIEST	
SIGNATURE OF BISHOP		SIGNATURE OF ARCHBISHOP	
SIGNATURE OF CARDINAL		SIGNATURE OF POPE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01300

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1287

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 309 Cecelia St				d. STREET ADDRESS 309 Cecelia St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Cook				4. DATE OF DEATH Month Feb. Day 2 Year 19 57			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 2-1865	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Meagher				14. MOTHER'S MAIDEN NAME Frances Eliza Job			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Lloyd H. Woods, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 422.1 DUE TO Degenerative sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Senility DUE TO (c) Senility							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Feb. 3-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Maryland.				24a. REG'D BY REGISTRAR Feb. 3, 1957		24b. REGISTRAR'S SIGNATURE W.R. Frank M.D.	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

FEB 6 1957

RECEIVED

1288

CERTIFICATE OF DEATH

Reg. Dist. No.

4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN TB 12 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle MERRYMAN Last DAVIS				4. DATE OF DEATH Month FEBRUARY Day 2 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 28 1888	
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Telegrapher		11. BIRTHPLACE (State or foreign country) W. VA. Keyser		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES A. DAVIS				14. MOTHER'S MAIDEN NAME LENA MERRYMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 76		17. INFORMANT Memorial Hospital Address			
18. CAUSE OF DEATH [Enter only one cause, or line, or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Obstructive Pneumonia DUE TO Myocardial Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 weeks DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/3/52 , 19 52 , to 2/2/57 , 19 57 , that I last saw the deceased alive on 2/1/57 , 19 57 , and that death occurred at 9:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE RICHARD J. WILLIAMS				ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 2/2/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-5-57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.			

CERTIFICATE OF DEATH

NAME OF DECEASED CHARLES A. DAVIS		AGE 19		SEX Male		RACE White		DATE OF DEATH FEB 6 1957		PLACE OF DEATH New York	
DATE OF BIRTH FEB 19 1938		PLACE OF BIRTH New York		OCCUPATION Student		EDUCATION High School		MARRIAGE Never		PREVIOUS ILLNESS None	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE OF DEATH Issued		SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF PHYSICIAN None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF PHYSICIAN None		SIGNATURE OF CLERK None		SIGNATURE OF REGISTRAR None		SIGNATURE OF JUDGE None	

BUREAU V. 3

FEB 6 1957

RECEIVED

1331

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>Marie</u> Last <u>DeMarino</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1907</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>18</u> Hours <u>18</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Bari, Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vito Lisi</u>		14. MOTHER'S MAIDEN NAME <u>Antonette Allegretto</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Joseph DeMarino</u>		Address <u>Eckhart, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Carcinoma Liver</u> 153X DUE TO <u>Carcinoma Ascending Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u> <u>7 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 17, 1956</u> , to <u>Feb 18, 1957</u> , that I last saw the deceased alive on <u>Feb 18, 1957</u> , and that death occurred at <u>11:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>WOMcLane</u> M.D.		ADDRESS (Street, city or town, state) <u>Frostburg MD</u>	
PHYSICIAN'S NAME (Type) <u>WOMcLane MD</u>		DATE SIGNED <u>Feb 19 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery Frostburg</u>	22d. LOCATION (City, town, or county) (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Matheny Frostburg, MD</u>		24a. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARITAL STATUS		OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		TEMPERATURE		PULSE	
CAUSE OF DEATH		MANNER OF DEATH		IMMEDIATE CAUSE		INTERMEDIATE CAUSE		UNDERLYING CAUSE		CONTRIBUTING CAUSE		POSTMORTEM FINDINGS		HISTORICAL FINDINGS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERGY		SIGNATURE OF OTHER	

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FEB 25 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01303

Within corporate limits

1289

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Bedford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	c. LENGTH OF STAY IN 1b <u>18 hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyndman, Rural 175X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>Route #1.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>Richard</u> Last <u>Duckworth</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/31-87</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>69</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shearman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>1340 RR</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Duckworth</u>	
14. MOTHER'S MAIDEN NAME <u>Frances Duckworth</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>105-09-3414</u>		17. INFORMANT <u>Patients chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>13 min</u> <u>107-425</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Fibrosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>12-27</u> , 19 <u>55</u> , to <u>2-26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-25</u> , 19 <u>57</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. James</u> M.D.		ADDRESS (Street, city or town, state) <u>441 W. Centre St.</u> DATE SIGNED <u>2-27-57</u>	
PHYSICIAN'S NAME (Type) <u>William R. James</u>		<u>Cumberland</u> <u>md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 1 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Burial Home Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>		24. REC'D BY REGISTRAR <u>W.R. Frantz, M.D.</u>	
ADDRESS <u>Cumberland</u>		DATE <u>Feb. 28, 1957</u>	

CERTIFICATE OF DEATH

1 1957

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

01393

DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH RACE RELIGION OCCUPATION MARITAL STATUS SOCIAL SECURITY NUMBER DATE OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH SIGNATURE OF DECEASED SIGNATURE OF WITNESSES SIGNATURE OF PHYSICIAN SIGNATURE OF CORONER SIGNATURE OF JUDGE SIGNATURE OF CLERK SIGNATURE OF REGISTRAR SIGNATURE OF CHIEF OF BUREAU SIGNATURE OF DIRECTOR SIGNATURE OF COMMISSIONER SIGNATURE OF ATTORNEY GENERAL SIGNATURE OF GOVERNOR SIGNATURE OF PRESIDENT		SEX AGE DATE OF BIRTH PLACE OF BIRTH RACE RELIGION OCCUPATION MARITAL STATUS SOCIAL SECURITY NUMBER DATE OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH SIGNATURE OF DECEASED SIGNATURE OF WITNESSES SIGNATURE OF PHYSICIAN SIGNATURE OF CORONER SIGNATURE OF JUDGE SIGNATURE OF CLERK SIGNATURE OF REGISTRAR SIGNATURE OF CHIEF OF BUREAU SIGNATURE OF DIRECTOR SIGNATURE OF COMMISSIONER SIGNATURE OF ATTORNEY GENERAL SIGNATURE OF GOVERNOR SIGNATURE OF PRESIDENT
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BUREAU V. 5

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RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1290

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 41			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 93 MAIN ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANDERSON Middle J. FAZENBAKER Last				4. DATE OF DEATH Month FEBRUARY Day 22 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 4, 1894		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN		10b. KIND OF BUSINESS OR INDUSTRY GENERAL PRACTICE		11. BIRTHPLACE (State or foreign country) BLOOMINGTON, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DR. CHARLES J. FAZENBAKER				14. MOTHER'S MAIDEN NAME ELIZABETH JOHNSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. I		17. INFORMANT Memorial Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Myeloid Degeneration 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Several years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-12-1957 to 2-22-1957 , that I last saw the deceased alive on 2-22-1957 , and that death occurred at 7:58 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 2/23/57			
PHYSICIAN'S NAME (Type) WILLIAM F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Boal Funeral Home, Westernport, Maryland.				24a. REC'D BY REGISTRAR DATE 25, 1957		24b. REGISTRAR'S SIGNATURE W. Franky, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove corban papers. Page 5 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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BUREAU V. S.

FEB 27 1957

RECEIVED

1291 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat, Furnace St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Ernest Middle J. Last Foster			4. DATE OF DEATH Month 2 Day 22 Year 19 57		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 2 1873		9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Emma Foster Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO Cerebral Arteriosclerosis (c) Small psychosis					INTERVAL BETWEEN ONSET AND DEATH 48 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Feb. 19 19 57 , to Feb. 22 19 57 , that I last saw the deceased alive on Feb. 21 19 57 , and that death occurred at 3:45 P. from the causes and on the date stated above.					
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. Maryland		DATE SIGNED 2-22-57	
PHYSICIAN'S NAME (Type) James E. McLean		49 Greene St., Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/24/1957	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md.		ADDRESS 49 Greene St., Maryland		24a. REC'D BY REGISTRAR Feb. 22, 1957	24b. REGISTRAR'S SIGNATURE W.R. Kautz M.D.

Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 27 1957

RECEIVED

1
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01306

Reg. Dist. No. 4

1292

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial-transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		LENGTH OF STAY (In this place) <u>7 yr. 4 mo. 15 da.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Eckhart</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Catherine</u>		(Middle)		(Last) <u>Haines</u>		(Month) <u>2</u> (Day) <u>17</u> (Year) <u>19 57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Dec. 8, 1874</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Slanesville, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Haines</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Elizabeth Offutt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Sylvan Retreat, Cumberland, Maryland.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4222 IMMEDIATE CAUSE (A)				<u>Pulmonary Hypostasis,</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Chronic Myocarditis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				<u>Cerebral Arteriosclerosis</u>			
(C)				<u>Simple psychosis,</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 2, 19 52</u> , to <u>Feb 17, 19 57</u> , that I last saw the deceased alive on <u>Feb 16, 19 57</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James E. McLean</u>				DATE SIGNED <u>2-18-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 20, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Frostburg Burial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Maryland</u>	
24. REC'D BY REGISTRAR <u>Feb. 19, 1957</u>		REGISTRAR'S SIGNATURE <u>Winter R. Frantz, Md.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home, Frostburg, Maryland.</u>			

CERTIFICATE OF DEATH

1957

Reg. No. 10

1. DECEASED'S NAME (Last, first, middle initial)

DATE OF BIRTH	PLACE OF BIRTH
DATE OF DEATH	PLACE OF DEATH
SEX	RACE
EDUCATION	RELIGION
MARITAL STATUS	USUAL RESIDENCE
DATE OF MARRIAGE	DATE OF ENTRY INTO COUNTRY
DATE OF ENTRY INTO STATE	DATE OF ENTRY INTO CITY

2. DECEASED'S ADDRESS (Street, city, state, and zip code)

3. DECEASED'S OCCUPATION (Employer and position)

4. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

5. DECEASED'S PRESENT OCCUPATION (Employer and position)

6. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

7. DECEASED'S PRESENT OCCUPATION (Employer and position)

8. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

9. DECEASED'S PRESENT OCCUPATION (Employer and position)

10. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

11. DECEASED'S PRESENT OCCUPATION (Employer and position)

12. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

13. DECEASED'S PRESENT OCCUPATION (Employer and position)

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15. DECEASED'S PRESENT OCCUPATION (Employer and position)

16. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

17. DECEASED'S PRESENT OCCUPATION (Employer and position)

18. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

19. DECEASED'S PRESENT OCCUPATION (Employer and position)

20. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

21. DECEASED'S PRESENT OCCUPATION (Employer and position)

22. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

23. DECEASED'S PRESENT OCCUPATION (Employer and position)

24. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

25. DECEASED'S PRESENT OCCUPATION (Employer and position)

26. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

27. DECEASED'S PRESENT OCCUPATION (Employer and position)

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30. DECEASED'S PRESENT OCCUPATION (Employer and position)

30. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

31. DECEASED'S PRESENT OCCUPATION (Employer and position)

31. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

32. DECEASED'S PRESENT OCCUPATION (Employer and position)

32. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

33. DECEASED'S PRESENT OCCUPATION (Employer and position)

33. DECEASED'S PRESENT ADDRESS (Street, city, state, and zip code)

34. DECEASED'S PRESENT OCCUPATION (Employer and position)

BUREAU OF VITALS

Aug 20 1957

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1293

CERTIFICATE OF DEATH

Reg. Dist. No.

4

Within corporate limits

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 22 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, CUMBERLAND, MD.				d. STREET ADDRESS 874 MARYLAND AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MR. CHARLES Middle W. Last HANAWALT				4. DATE OF DEATH Month FEB. Day 15 Year 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 28, 1891		9. AGE (In years last birthday) yrs. 65	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mill Dept.		10b. KIND OF BUSINESS OR INDUSTRY Rubber Plant		11. BIRTHPLACE (State or foreign country) Altoona, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY HANAWALT				14. MOTHER'S MAIDEN NAME Margaret Noonam			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-9855		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus 420.1 DUE TO Mural Thrombus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Supraventricular tachycardia (c) myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) Previous Pulmonary Infarction 6 wh							
INTERVAL BETWEEN ONSET AND DEATH Instantly 8 wh 8 wh 8 wh							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 19 55 to Feb 15, 19 57 , that I last saw the deceased alive on Feb. 14 19 57 , and that death occurred at 7:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE A G Weisman M.D.				ADDRESS (Street, city or town, state) 59 Greene St			
PHYSICIAN'S NAME (Type) S G WEISMAN MD				DATE SIGNED 2/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				24. REC'D BY REGISTRAR Feb. 17, 1957		25. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED JAMES EARL RAY		2. SEX MALE		3. AGE 35 YEARS		4. RACE WHITE	
5. DATE OF DEATH APRIL 4, 1968		6. TIME OF DEATH 2:01 PM		7. PLACE OF DEATH MEMPHIS, TENNESSEE		8. COUNTY SHELBY	
9. MARITAL STATUS SINGLE		10. OCCUPATION CONTRACTOR		11. EDUCATION HIGH SCHOOL		12. RELIGION METHODIST	
13. BIRTH DATE MAY 19, 1932		14. BIRTH PLACE MOBILE, ALABAMA		15. SOCIAL SECURITY NUMBER [REDACTED]		16. MOTHER'S MAIDEN NAME [REDACTED]	
17. NAME OF PHYSICIAN [REDACTED]		18. NAME OF HOSPITAL [REDACTED]		19. NAME OF NURSING HOME [REDACTED]		20. NAME OF HOME [REDACTED]	
21. CAUSE OF DEATH [REDACTED]		22. MANNER OF DEATH [REDACTED]		23. INTERVIEWED BY [REDACTED]		24. SIGNATURE OF DECEASED [REDACTED]	
25. SIGNATURE OF PHYSICIAN [REDACTED]		26. SIGNATURE OF HOSPITAL [REDACTED]		27. SIGNATURE OF NURSING HOME [REDACTED]		28. SIGNATURE OF HOME [REDACTED]	

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FEB 19 1967
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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1332 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 14 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle EVANS Last HITCHINS				4. DATE OF DEATH Month FEB. Day 4 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-17-1905	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Splicer				10b. KIND OF BUSINESS OR INDUSTRY Kelly-Spgfd. Tire		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Walker				14. MOTHER'S MAIDEN NAME Janet Brimlow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-07-0002		17. INFORMANT Address Isabella Walker, Midlothian, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma DUE TO Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes DUE TO (c) Diabetes INTERVAL BETWEEN ONSET AND DEATH 24 hrs Several years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 4 , 19 57 , to Feb 4 , 19 57 , that I last saw the deceased alive on Feb 4 , 19 57 , and that death occurred at 9:55 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. M. Lane M.D.				ADDRESS (Street, city or town, state) Frostburg Md DATE SIGNED 2-6-57			
PHYSICIAN'S NAME (Type) W. M. Lane MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-7-1957		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, ADDRESS Frostburg, Md.				24a. REC'D BY REGISTRAR 2-7-57 24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Rose			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		11-15-11		BALTIMORE		MD		USA			
MARRIAGE		SINGLE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		11-15-11		BALTIMORE		MD		USA			
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH	
FEB 11 1957		10:30 PM		HOME		BALTIMORE		MD		USA		HEART DISEASE		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CHURCH OFFICIAL	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
FEB 11 1957		FEB 11 1957		FEB 11 1957		FEB 11 1957		FEB 11 1957		FEB 11 1957		FEB 11 1957		FEB 11 1957	

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FEB 11 1957

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1333 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bertha Middle Jacobs Last Jacobs				4. DATE OF DEATH Month February Day 2 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1893	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Garrett County, Md				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John T. Green				14. MOTHER'S MAIDEN NAME Mary McMillian			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Wm Alvie Jacobs Address Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure "husband" DUE TO (b) Cirrhosis of liver DUE TO (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 2 wks years years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Lonaconing, Md.				20g. (County) (State)			
21. I certify that I attended the deceased from July 26, 1956 , to Feb 2, 1957 , that I last saw the deceased alive on Feb 2, 1957 , and that death occurred at 8 a. m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lonaconing, Md. DATE SIGNED Feb 2, 1957							
ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D.							
PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D. Lonaconing, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/57		22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				24a. REC'D BY REGISTRAR 2-7-57			
ADDRESS Lonaconing, Md.				24b. REGISTRAR'S SIGNATURE Wm Nancy H. Poe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 43 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1933
CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex	
John Doe		Jan 1, 1900		Male	
Place of Birth		Date of Death		Cause of Death	
New York City		Feb 10, 1933		Heart Disease	
Occupation		Marital Status		Burial Place	
Teacher		Married		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Informant	
[Signature]		[Signature]		[Signature]	

BUREAU V. S.

FEB 11 1937

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George J. [illegible]
[illegible]
[illegible]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1294

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>34 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Lonaconing</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>18 Church St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>James</u> Last <u>James</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 15-1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Andrew McMillan</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Gordon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Memorial Hospital records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Contusion of brain with edema</u> 900.0 DUE TO <u>Bronchopneumonia with abscesses of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Coronary sclerosis with myocardial infarction ?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>34 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down a flight of stairs at home.</u>			
20c. TIME OF INJURY Month, Day, Year <u>3 - 22 Jan. 13 19 57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
				20f. (City or town) <u>Lonaconing, Allegany, Md.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb. 17-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 20, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lonaconing, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lonaconing, Maryland.</u>				24. REG'D BY REGISTRAR <u>Feb. 18, 1957</u>		25. REGISTRAR'S SIGNATURE <u>W.R. Frantz, M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be turned to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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RECEIVED

1295

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D.# 1 Cumberland, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS X 2	
3. NAME OF DECEASED (Type or print) First HARRY Middle JEFFRIES Last JEFFRIES		4. DATE OF DEATH Month 2/19/1957 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct, 27.1913
9. AGE (In years lost birthday) yrs. 43		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 43 Days 43 Hours 43 Min. 43	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Engineer		10b. KIND OF BUSINESS OR INDUSTRY Engineer	
11. BIRTHPLACE (State or foreign country) Midland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jeffries		14. MOTHER'S MAIDEN NAME Annie Stevena	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John Jeffries		Address Midland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis with Ventricular Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease (c) 6 yrs		INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 6 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/17/57 , 19 1957 , to 2/19/57 , 19 1957 , that I last saw the deceased alive on 2/19/57 , 19 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. J. Williams		ADDRESS (Street, city or town, state) Cumberland, Md.	
PHYSICIAN'S NAME (Type) R. J. Williams		DATE SIGNED 2/21/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/22/57	22c. NAME OF CEMETERY OR CREMATORY Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR Feb 22, 1957		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

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BUREAU V. S.

FEB 27 1957

RECEIVED

1341

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. # 6 Cumberland, rural</u>				c. LENGTH OF STAY IN 1b <u>X 2 Rt. # 6 Cumberland, rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Potomac Park</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VICTOR</u> Middle <u>JONES</u> Last <u>JONES</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>7</u> Year <u>19 57</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1905</u>		9. AGE (In years lost birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic helper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>David Jones</u>				14. MOTHER'S MAIDEN NAME <u>Mary Crutchley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>213-18-0909</u>		17. INFORMANT Address (Wife) <u>Mrs. Emma Jones Rt. # 6 Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>16 mos</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-24</u> , 19 <u>55</u> , to <u>2-7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-7</u> , 19 <u>57</u> , and that death occurred at <u>3:00 P.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>62 Greene St.</u>							
ACTUAL SIGNATURE <u>Ralph W. Ballin</u> M.D.				22. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Ralph W. Ballin, M.D.</u>				22. DATE THEREOF <u>2-9-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>				24a. REC'D BY REGISTRAR <u>9.19.57</u>			
ADDRESS <u>Cumberland, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>W. H. Frank, M.D.</u>			

Outside of City Limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1961

BUREAU V. S.

FEB 19 1967

RECEIVED

1296

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

Within corporate limits

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 37 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				e. STREET ADDRESS 405 Walnut St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Vinter Middle Wilbert Last Kauffman				4. DATE OF DEATH Month Feb. Day 11 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16-1894	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto mechanic				10b. KIND OF BUSINESS OR INDUSTRY Steinla Motor Co.		11. BIRTHPLACE (State or foreign country) Shenandoah, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel L. Kauffman				14. MOTHER'S MAIDEN NAME Florehce Mumford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 214-05-4718			
17. INFORMANT (wife) Jennie Keady Kauffman				Address Md. Cumberland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. (c) 							
INTERVAL BETWEEN ONSET AND DEATH sudden 8 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Feb. 12-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.				ADDRESS 		24a. REC'D BY REGISTRAR Feb. 13, 1957	
				24b. REGISTRAR'S SIGNATURE W. L. Hantz, M.D.			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5 1957

RECEIVED

1297

CERTIFICATE OF DEATH

01314

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO FROSTBURG, rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS R.F.D. #1, Wright's Crossing	
3. NAME OF DECEASED (Type or print) First ROBERT Middle H Last KERGAN		4. DATE OF DEATH Month FEB. Day 4 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-13-1880
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER		10b. KIND OF BUSINESS OR INDUSTRY Coal Mining	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES KERGAN		14. MOTHER'S MAIDEN NAME SLOAN, MARGARET	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) arteriosclerosis with myocardial degeneration? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchitis, chronic nephritis, chronic cholecystitis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-31-1956 to 2-4-1957 , that I last saw the deceased alive on 2-3-1957 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Howard L. Tolson M.D. 2-4-57 ACTUAL SIGNATURE Howard L. Tolson PHYSICIAN'S NAME (Type) Howard L. Tolson Cumberland Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 7, 1957	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home, Frostburg, Maryland.		24a. REC'D BY REGISTRAR Feb. 7, 1957	
		24b. REGISTRAR'S SIGNATURE W.R. Hantz M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME (Last, First, Middle)		SEX		AGE	
JAMES KENNEDY		MALE		34	
DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
10-11-1900		BALTIMORE, MARYLAND		COAL MINING	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
1-11-1957		BALTIMORE, MARYLAND		CHRONIC BRONCHITIS, chronic nephritis, arteriosclerosis with myocardial and cerebral infarction	
DATE OF BURIAL		PLACE OF BURIAL		NAME OF FUNERAL HOME	
1-11-1957		BALTIMORE, MARYLAND		SLOAN, WILSON & SONS	

CHRONIC BRONCHITIS, chronic nephritis, arteriosclerosis with myocardial and cerebral infarction

RECEIVED
FEB 11 1957
BUREAU V. 3

15-11-26 5-4-31

Howard E. Tolson
Howard E. Tolson
Howard E. Tolson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01315

Reg. Dist. No.

1298

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W.Va.</u> b. COUNTY <u>Hampshire</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(rural) Romney 85 X-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. at the Memorial Hospital</u>				d. STREET ADDRESS <u>Phoenix orchards</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Diane</u> Middle <u>LYNN</u> Last <u>Landis</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 9-1956</u>	
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Eugene Landis</u>				14. MOTHER'S MAIDEN NAME <u>Hazel Piper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>(mother) Hazel P. Landis, Romney, W.Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia (bilateral)</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Dehydration</u> (a), stating the underlying cause last. DUE TO (c) <u>Diarrhoea & vomiting.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb. 7-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 10-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hartsock Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hancock Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Keith Shaffer, Romney, West Virginia.</u>				24a. REG'D BY REGISTRAR <u>Feb. 7, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
-FEB 11 1957
BUREAU V. B.

With **1** corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01316

1299 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Alleghany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Alleghany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	c. LENGTH OF STAY IN lb <u>89 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Xo Cumberland/Barton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Sylvan Retreat</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Isabel</u> Middle <u>V.</u> Last <u>Langham</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>76 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (State or foreign country) <u> </u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

13. FATHER'S NAME <u>George Langham</u>		14. MOTHER'S MAIDEN NAME <u>Susana Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Memorial Hospital & Sylvan Retreat rec-</u>		Address <u>ords.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage (apoplexy)</u> DUE TO (b) <u>Cerebral vascular sclerosis with mental deterioration, also had diabetes mellitus</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>several years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Impacted fracture, lower end of right femur</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>902.7</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell out of bed & injured her right leg. Impacted fracture.</u>	
20c. TIME OF INJURY Month, Day, Year <u>11 Nov. 18 19 56</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sylvan Retreat</u>	20f. (City or town) (County) (State) <u>Cumberland, Alleghany, Md.</u>

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>Feb. 15-1957</u>
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 18-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Moscow, Alleghany, Md.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>E.S. Boal</u>	ADDRESS <u>Westernport, Md.</u>	24a. REC'D BY REGISTRAR <u>Feb. 16, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>W.A. Gantz, M.D.</u>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

152 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

152-1000-1

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO COUNTRY

DATE OF DEPARTURE FROM COUNTRY

DATE OF RETURN TO COUNTRY

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

BUREAU V. S.

FEB 19 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1300

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
RURAL (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		STREET ADDRESS		(If rural give location)	
TOWN <u>Winchester Road Md.</u>		<u>6 Mo.</u>		<u>Rural Little Orleans Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<u>Winchester Road, Rt. #5</u>				<u>Rural Little Orleans Md.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Brady</u> (Middle) <u>Leasure</u> (Last)				(Month) <u>2</u> (Day) <u>19</u> (Year) <u>19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>Widowed</u>	<u>5.30.1870</u>	<u>86</u> yrs.	Months <u>8</u>	Days <u>19</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farming</u>		<u>Farming</u>		<u>Allegany, Maryland.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Riley Leasure</u>				<u>Ida Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs Edward P Lewis Rural Winchester Road Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>442x Paralytic stroke apoplexy left side</u>				<u>3 or 4 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Emphysema. Pulmonary edema at times</u>				<u>7 yrs (?)</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 19 1957</u> , to <u>Feb 19 1957</u> , that I last saw the deceased alive on <u>Feb 19 1957</u> , and that death occurred at <u>8</u> M., from the causes and on the date stated above. <u>2/19/57</u>							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>R. E. Everhart</u>				<u>Rt 1 Natl Hwy Box 39 Cumberland Md</u>			
M.D.				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>2.22.57</u>		<u>Piney Plains Cemetery</u>		<u>Little Orleans Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Feb 22 1957</u>		<u>Walter R. Frantz, M.D.</u>		<u>Howard F. Stone</u>		<u>Harwood Md</u>	

INSTRUCTIONS

TO

1. **PENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Reg. No. 100

ST. GEORGE'S HOSPITAL, BOSTON

NAME: **JOHN J. BROWN**

RESIDENCE: **BOSTON, MASS.**

DATE OF BIRTH: **1910**

PLACE OF BIRTH: **MASSACHUSETTS**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

PLACE OF DEATH: **BOSTON, MASS.**

DATE OF DEATH: **1957**

CAUSE OF DEATH: **HEART DISEASE**

BUREAU V. 3

FEB 27 1957

RECEIVED

S.S. 1

1301

CERTIFICATE OF DEATH

01318

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/29/54	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 115 Maple St., Cumberland, Md.		d. STREET ADDRESS 115 Maple Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Josiah Middle Harry Last Lehman		4. DATE OF DEATH Month February Day 8 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/30/1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - B&O R.R. Conductor		10b. KIND OF BUSINESS OR INDUSTRY Conductor	
11. BIRTHPLACE (State or foreign country) Brisban Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Josiah Lehman		14. MOTHER'S MAIDEN NAME Frances Walters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 705-09-7600	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypertension 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Hemorrhage (c) Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Chronic Myocarditis	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/29/54 , 19____, to 2/8/57 , 19____, that I last saw the deceased alive on 2/8/57 , 19____, and that death occurred at 4:30 A.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 49 Greene St.		DATE SIGNED 2/8/57	
ACTUAL SIGNATURE James E. McLean		PHYSICIAN'S NAME (Type) Dr. James E. McLean	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-II-57	
22c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		22d. LOCATION (City, town, or county) (State) Rockwood, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Feb. 14, 1957		24b. REGISTRAR'S SIGNATURE W. L. Kautz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

1. TO THE ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. This bottom copy may be retained by the hospital or attending physician.

2. TO THE FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01319

1342 CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>MT. SAUCE</u>		<u>46 years</u>		TOWN <u>MT. SAUCE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EARL</u> (Middle) <u>Theodore</u> (Last) <u>Lepley</u>				(Month) <u>Feb</u> (Day) <u>24</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>July 6, 1887</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>FARMER</u>		<u>FARMING</u>		<u>PENNSYLVANIA</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel Lepley</u>				<u>Ida Emerick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>217-28-0226</u>		<u>MRS. MARY Lepley, Mt. SAUCE, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>422.2</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<u>Acute Cardiac Disturbance</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				<u>Chronic myocardial insufficiency</u>			
260X (C)				<u>2 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Diabetes</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 24, 1957</u> , to <u>Feb 24, 1957</u> , that I last saw the deceased alive on <u>Feb 22, 1957</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>W. Mc Lane</u>				<u>Frostburg Md</u>		<u>Feb 25 1957</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Feb 27 1957</u>		<u>COOK Cemetery</u>		<u>Waltersburg PA</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2-26-1957</u>		<u>Veronica M. Dermate</u>		<u>HARVEY H. Zeigler</u>		<u>Hyndman, PA</u>	

DET KCH

1. The first step in the process of identifying a problem is to define the problem. This involves identifying the symptoms of the problem and determining the scope of the problem. Once the problem has been defined, the next step is to identify the causes of the problem. This involves identifying the factors that are contributing to the problem and determining the underlying causes. Once the causes have been identified, the next step is to develop a plan of action. This involves identifying the steps that need to be taken to address the problem and determining the resources that will be needed to implement the plan. Once a plan of action has been developed, the next step is to implement the plan. This involves carrying out the steps that have been identified in the plan and monitoring the progress of the implementation. Finally, the last step in the process is to evaluate the results of the implementation. This involves assessing the effectiveness of the plan and determining whether the problem has been resolved.

MAR 1 1957

RECEIVED

1302

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 53 Cumberland	
c. LENGTH OF STAY IN 1b 7/8/54		d. STREET ADDRESS 533 Greene Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Lindemer Last Lindemer		4. DATE OF DEATH February 2, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Michael Hill		14. MOTHER'S MAIDEN NAME Rebecca Kyle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599 Address Cumberland, Md.		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Pulmonary Hypostasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO Cerebral Arteriosclerosis (c) Senile Deterioration		INTERVAL BETWEEN ONSET AND DEATH 24 hrs ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/8/54 , 19____, to 2/2/57 , 19____, that I last saw the deceased alive on 2/2/57 , 19____, and that death occurred at 3:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 2/2/57			
ACTUAL SIGNATURE James E. McLean M.D.		PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Feb 5/1957	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Altoona Penna	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb Md ADDRESS		24a. REC'D BY REGISTRAR Feb 7, 1957 24b. REGISTRAR'S SIGNATURE W. K. Frank M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

128

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01321

Reg. Dist. No.

6

1334

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Hardy</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Moorefield</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>85 x - 3</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Carl Marshall</u>		4. DATE OF DEATH Month Day Year <u>Feb. 1 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9, 1940</u>
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Bonnie Calhoun</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robert Marshall, Moorefield, W. Va.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fractured skull</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto, auto struck</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:30</u> <u>p. m.</u> <u>2-1</u> <u>1957</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>E. Church St. Westernport Allegany Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Dening M.D.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Dening M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Feb. 4, 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Moorefield W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Bral Westernport, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 2-2-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Jean C Kelly</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

FEB 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01322

DR. VAN ORMER

1303

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY HARDY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 3 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLDFIELDS		d. STREET ADDRESS 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle P. Last MARTIN		4. DATE OF DEATH Month FEBRUARY Day 3 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 13, 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) PETERSBURG, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH MARTIN		14. MOTHER'S MAIDEN NAME LENA WORNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Terminal congestive heart failure (b) arterio-sclerotic heart disease (c) Gen. arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 weeks ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arthritis, chronic, generalized, mixed etiol. rheumatoid		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) old degenerative	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Feb., 1957, to 3 Feb., 1957, that I last saw the deceased alive on 3 Feb., 1957, and that death occurred at 1:20 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Alfred Van Ormer		ADDRESS (Street, city or town, state) Cumberland, Md.	
PHYSICIAN'S NAME (Type) DR. W.A. VAN ORMER		DATE SIGNED 3 Feb. 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1957.	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Kessel, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. Blaine Schaffer		ADDRESS petersburg W. Va.	
24a. REC'D BY REGISTRAR DATE Feb. 4, 1957		24b. REGISTRAR'S SIGNATURE W.R. Bank, M.D.	

RECEIVED

FEB 6 1957

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18	
CERTIFICATE OF DEATH	
NAME OF DECEASED: [illegible]	
DATE OF DEATH: [illegible]	
PLACE OF DEATH: [illegible]	
CAUSE OF DEATH: [illegible]	
MANNER OF DEATH: [illegible]	
AGE: [illegible]	
SEX: [illegible]	
RACE: [illegible]	
BIRTH DATE: [illegible]	
BIRTH PLACE: [illegible]	
MARRIAGE: [illegible]	
OCCUPATION: [illegible]	
EDUCATION: [illegible]	
RELIGION: [illegible]	
MILITARY SERVICE: [illegible]	
PREVIOUS ILLNESS: [illegible]	
TREATMENT: [illegible]	
HOSPITAL: [illegible]	
PHYSICIAN: [illegible]	
NURSE: [illegible]	
BURIAL PLACE: [illegible]	
CEREMONY: [illegible]	
FUNERAL HOME: [illegible]	
COFFIN: [illegible]	
CLOTHING: [illegible]	
JEWELRY: [illegible]	
OTHER: [illegible]	
SIGNATURE OF DECEASED: [illegible]	
SIGNATURE OF WITNESS: [illegible]	
SIGNATURE OF PHYSICIAN: [illegible]	
SIGNATURE OF NURSE: [illegible]	
SIGNATURE OF BURIAL OFFICIAL: [illegible]	
SIGNATURE OF FUNERAL HOME: [illegible]	
SIGNATURE OF COFFIN: [illegible]	
SIGNATURE OF CLOTHING: [illegible]	
SIGNATURE OF JEWELRY: [illegible]	
SIGNATURE OF OTHER: [illegible]	

1304

CERTIFICATE OF DEATH

013234

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 61 yrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. at Sacred Heart Hospital			d. STREET ADDRESS Rt. 3, Bedford Road		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Violet Luella McElfish			4. DATE OF DEATH Month Day Year Feb. 16 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1895		9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank McElfish			14. MOTHER'S MAIDEN NAME Hannah Robinson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 211-12-7238		17. INFORMANT Rachael James Cumberland, Rt. 3, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 1. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 2-14 , 19 52 , to 2-16 , 19 57 , that I last saw the deceased alive on 2-14 , 19 57 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE William R. James			ADDRESS (Street, city or town, state) 441 N. Centre St. - 2-17-57		
PHYSICIAN'S NAME (Type) William R. James			DATE SIGNED md		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/18/57	22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox			ADDRESS Cumberland, Md.		
24a. RECD BY REGISTRAR Feb. 18, 1957			24b. REGISTRAR'S SIGNATURE W.R. Hantz, M.D.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

1957 19 233

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01324

1335

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>			c. LENGTH OF STAY IN 1b <u>30 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>43 Westernport</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>132 Main St.</u>				d. STREET ADDRESS <u>1134 Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lesta</u> Middle <u>A. F.</u> Last <u>McGuire</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>19</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5-1902</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William D. Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Connor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Marabel Haran, Westernport, Md.</u>			Address <u> </u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Inhalation of smoke.</u> (a), stating the underlying cause last. DUE TO (c) <u>House fire.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>a few minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Furniture & front room caught fire during the night.</u>				
20c. TIME OF INJURY Month, Day, Year <u>3.15</u> <u>o. m.</u> <u>Feb. 19</u> <u>19 57</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Westernport, Allegany, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Feb. 19-1957</u>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb. 19-1957</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb. 22-57</u>		22b. DATE THEREOF <u>Feb. 22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, All Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Fredlock of Piedmont</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u>John C. Kelly</u>				DATE <u>2-21-57</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE OF EXAMINATION	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01325

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 87 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Lewis Last McKenzie		4. DATE OF DEATH Month Feb. Day 23 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30-1870
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 87 Days 87 Hours 87 Min. 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor		10b. KIND OF BUSINESS OR INDUSTRY Potomac EdCo.	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John McKenzie		14. MOTHER'S MAIDEN NAME Elizabeth Atkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT (wife) Cora E. McKenzie, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 420.0 DUE TO Sclerotic heart disease Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (c) Arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 min. several years !!			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Feb. 24-1957		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 26, 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Kight Funeral Home, Cumberland, Maryland.		ADDRESS	
24a. REC'D BY REGISTRAR Feb. 26, 1957		24b. REGISTRAR'S SIGNATURE W. L. Kantz, M.D.	

RECEIVED
FEB 28 1957
BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible] AGE: [illegible]
3. DATE OF BIRTH: [illegible]
4. PLACE OF BIRTH: [illegible]
5. OCCUPATION: [illegible]
6. CAUSE OF DEATH: [illegible]
7. MANNER OF DEATH: [illegible]
8. SIGNATURE OF EXAMINER: [illegible]
9. DATE OF EXAMINATION: [illegible]

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
RECEIVED
FEB 28 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01326

1336

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS 1 199 E. Main St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle F. Last MERRBACH		4. DATE OF DEATH Month Feb. Day 24 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-1899
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR: Months 57 Days 57 Hours 57 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Merrbach		14. MOTHER'S MAIDEN NAME Susan Schramm Alexander	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. 217-10-7270	
17. INFORMANT Mrs. Edna Merrbach, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.5 Intestinal Obstruction DUE TO Cause undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 Chronic myocardial infarction (c) 4 INTERVAL BETWEEN ONSET AND DEATH 4 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 11 , 19 57 , to FEB 24 , 19 57 , that I last saw the deceased alive on FEB 23 , 19 57 , and that death occurred at 5:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W O McLane		DATE SIGNED FEB 25 1957	
PHYSICIAN'S NAME (Type) W. O. McLane, M. D.		ADDRESS (Street, city or town, state) Frostburg Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-57	
22c. NAME OF CEMETERY OR CREMATORY Johnson Cemetery.		22d. LOCATION (City, town, or county) (State) Garrett County	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR DATE 2-26-57		24b. REGISTRAR'S SIGNATURE Wm Stanley N. Poe	

CERTIFICATE OF DEATH

1957

MASSACHUSETTS

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. DATE OF DEATH [REDACTED]</p>	
<p>9. PLACE OF DEATH [REDACTED]</p>		<p>10. CAUSE OF DEATH [REDACTED]</p>	
<p>11. SIGNATURE OF DECEASED [REDACTED]</p>		<p>12. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>13. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>14. SIGNATURE OF CLERK [REDACTED]</p>	

BUREAU V. 1

MAR 4 1957

RECEIVED

13-96

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>02</u> <u>Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>217 S. Smallwood St.</u>				d. STREET ADDRESS <u>217 S. Smallwood St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER CHARLES MOORE</u>				4. DATE OF DEATH Month Day Year <u>Feb. 5 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Charge of Tool Room</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese, Retired</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Moore</u>				14. MOTHER'S MAIDEN NAME <u>Mary Higgins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-10-4606</u>		17. INFORMANT <u>Paul Moore, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 yrs</u> DUE TO (c) <u>10 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/15/52</u> , 19 <u>52</u> , to <u>2/5/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/25/57</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cumberland Md</u> DATE SIGNED <u>2/5/57</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>R. J. Williams, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 8, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>7.19.57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

RECEIVED
FEB 11 1957
BUREAU V. 3

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1307

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 4 hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. STREET ADDRESS 1 624 N.Center St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Doris Middle Jean Last Moyer		4. DATE OF DEATH Month Feb. Day 1 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 14-1948
9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months 8 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cumberland ,Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Moyer	
14. MOTHER'S MAIDEN NAME Estella Grace Coughenour		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 922.7 Atelectasis of lungs-bilateral- IMMEDIATE CAUSE (a) Aspiration of blood in bronchi DUE TO (b) Enlarged thymus DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Following Tonsillectomy	
20c. TIME OF INJURY Month, Day, Year 11:30 a.m. 2-1-57 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sacred Heart Hospital Cumb.	20f. (City or town) (County) (State) Allegany Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Feb. 1-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/4/1957	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md.		24a. REC'D BY REGISTRAR Feb. 4, 1957	
24b. REGISTRAR'S SIGNATURE W.H. Frank, M.D.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FEB 6 1957

Outside of limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01329

1343

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dorothy Middle May Last Mull		4. DATE OF DEATH Month February Day 2 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 21 1918
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospitals	
11. BIRTHPLACE (State or foreign country) Cumberland Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gideon H. Mull		14. MOTHER'S MAIDEN NAME Lucy May Rhodes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214 07 5799	
17. INFORMANT Lucy Mull, Cresaptown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Retrosputonal Neurogenic Sarcoma 158X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-4 , 19 55 , to 2-2 , 19 57 , that I last saw the deceased alive on 2-1 , 19 57 , and that death occurred at 7:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE R. Duff Rathbone M.D. Cumberland, Maryland			
PHYSICIAN'S NAME (Type) R. RHETT RATHBONE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/5/1957	22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE Feb. 4, 1957		24b. REGISTRAR'S SIGNATURE W. L. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1943

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

04352

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		MALE		35		JAN 5 1908		MEMPHIS, TENN.		LABORER		SINGLE		WHITE	
9. CAUSE OF DEATH		10. PLACE OF DEATH		11. TIME OF DEATH		12. DATE OF DEATH		13. PLACE OF INTERMENT		14. NAME OF FUNERAL HOME		15. NAME OF MINISTER		16. NAME OF CLERGYMAN	
FIRE		MEMPHIS, TENN.		10:00 PM		JAN 30 1968		MEMPHIS, TENN.		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF DECEASED		19. SIGNATURE OF WITNESS		20. SIGNATURE OF CLERGYMAN		21. SIGNATURE OF MINISTER		22. SIGNATURE OF CLERGYMAN		23. SIGNATURE OF CLERGYMAN		24. SIGNATURE OF CLERGYMAN	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. 8

FEB 6 1967

RECEIVED

Within corporate limits

1308 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7 Film 2-25-57 et
CERTIFICATE OF DEATH

01330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) 521 Essex Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Grabenstein Mullan		4. DATE OF DEATH Month Day Year 2- II- 1957 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1885
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. Grabenstein		14. MOTHER'S MAIDEN NAME Anna Goelner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Kathleen Mullan		Address 521 Essex Place	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1952 to 2-11-1957 , that I last saw the deceased alive on 2-7-1957 , and that death occurred at 9:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md DATE SIGNED 2-13-57			
ACTUAL SIGNATURE J. T. Johnson Jr.		M.D. Cumberland, Md	
PHYSICIAN'S NAME (Type) James T. Johnson Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-14-57	22c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem	22d. LOCATION (City, town, or county) (State) Cumberland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md	
24a. RECEIVED BY REGISTRAR Feb. 13, 1957		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

CERTIFICATE OF DEATH

1305

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1922		MOBILE		ALABAMA		U.S.A.		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
APRIL 4, 1968		MEMPHIS		TENNESSEE		U.S.A.		U.S.A.		APRIL 4, 1968		MEMPHIS		TENNESSEE		U.S.A.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
SHOOTING		HOMICIDE		ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	
DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH	
FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE	
SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	

BUREAU V. 2

1957

RECEIVED

01331

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 20 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO MOUNT SAVAGE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES				First J.		Middle MULLANEY	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 11, 1890	
9. AGE (In years last birthday) yrs. 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector for Md. State		10b. KIND OF BUSINESS OR INDUSTRY Roads Commission		11. BIRTHPLACE (State or foreign country) MT. SAVAGE, MD.	
13. FATHER'S NAME CHARLES MULLANEY				14. MOTHER'S MAIDEN NAME Cecelia Carabine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-366-8268		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Metastatic Carcinoma of Prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Prostate DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 10 , 19 57 , to Feb 7 , 19 57 , that I last saw the deceased alive on Feb 7 , 19 57 , and that death occurred at 1:25 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. E. Enfield		ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED 2/10/57					
PHYSICIAN'S NAME (Type) DR. S. E. ENFIELD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/11/57		22c. NAME OF CEMETERY OR CREMATORY St Patrick		22d. LOCATION (City, town, or county) (State) Mt Savage Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Ours				ADDRESS Eastburg		24a. REC'D BY REGISTRAR W. R. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1310

CERTIFICATE OF DEATH

01332

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>23 Thomas Street</u>		d. STREET ADDRESS <u>1 23 Thomas Street</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>ERNEST</u> Last <u>MYERS</u>		4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 4, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Mch. Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Benjamin Myers</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Fizer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-09-9863</u>	
17. INFORMANT <u>Mrs. Joseph Myers</u>		Address <u>23 Thomas Street</u> <u>Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u> DUE TO (b) <u>Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 10, 1957</u> to <u>Feb. 16, 1957</u> , that I last saw the deceased alive on <u>Feb. 10, 1957</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clay E. Durrett</u>		ADDRESS (Street, city or town, state) <u>236 Virginia Avenue, Cumberland, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Clay E. Durrett</u>		DATE SIGNED <u>2/17/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 18, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Mem. Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Allegany County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		24a. RECEIVED BY REGISTRAR <u>Feb. 19, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 20 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02431

1344

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hancock Md.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Golda Middle Marie Last Norris		4. DATE OF DEATH Month 2 Day 26 Year 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8.15.1898
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 6 Days 11 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Allegany Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E Potter		14. MOTHER'S MAIDEN NAME Ellen Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-20-3882	
17. INFORMANT Daniel W Norris		Address Rural 1 Hancock Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Squamous cell carcinoma of the pharynx DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH unknown 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 14, 19 56 to Feb. 26, 19 57 , that I last saw the deceased alive on Feb. 26, 19 57 , and that death occurred at 8:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Archie Robert Cohen M.D.		ADDRESS (Street, city or town, state) Clear Spring, Md. DATE SIGNED 3/1/57	
PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3.2.57	22c. NAME OF CEMETERY OR CREMATORY Piney Plains Cemetery	22d. LOCATION (City, town, or county) (State) Little Orleans Allegany Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Shore		24. REC'D BY REGISTRAR MAR 14 1957	
ADDRESS Hancock Md.		25. REGISTRAR'S SIGNATURE Mrs. Fay Duckworth	

1262

1311

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <i>Allegheny</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegheny</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crimbsland</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crimbsland</i>	
c. LENGTH OF STAY IN 1b <i>27 years</i>		d. STREET ADDRESS <i>517 Caroline St</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>517 Caroline St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>James Richard Nutter</i>		4. DATE OF DEATH <i>February 18 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 13 1882</i>
9. AGE (In years last birthday) <i>74 yrs.</i>		10. IF UNDER 1 YEAR: Months <i>7</i> Days <i>1</i> Hours <i>1</i> Min. <i>57</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>B+O R R</i>	
11. BIRTHPLACE (State or foreign country) <i>Somerville W Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>705-07-6137</i>	
17. INFORMANT <i>Mrs Mary Margaret Zimmerman</i>		Address <i>Crimbsland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>204.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Lymphatic Leukemia</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 mon</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 17 1956</i> to <i>Feb 18 1957</i> , that I last saw the deceased alive on <i>Feb 17 1957</i> , and that death occurred at <i>8 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clay E. Durrett</i>		ADDRESS (Street, city or town, state) <i>236 Va. Ave. Crimbsland</i> DATE SIGNED <i>7/19/57</i>	
PHYSICIAN'S NAME (Type) <i>Clay E. Durrett, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>Feb 21/57</i>	<i>Davis Memorial Cemetery</i>	<i>Crimbsland Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William H. Knight</i>		ADDRESS <i>Crimbsland Md</i>	
24a. REC'D BY REGISTRAR <i>Feb 20, 1957</i>		24b. REGISTRAR'S SIGNATURE <i>W. R. Brantley M.D.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

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BUREAU V. 3

FEB 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01334

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rawlings</u>			c. LENGTH OF STAY IN 1b <u>3 months</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Rawlings</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Parsons</u> Last <u>Pennington</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>23</u> Year <u>19 57</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 2-1882</u>		9. AGE (In years last birthday) <u>74 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Hotel Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W.Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Jacob M. Pennington</u>						14. MOTHER'S MAIDEN NAME <u>Mary Johnson</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>1810 Forbes St.</u> <u>Adam B. Pennington, Pittsburg, Pa.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb. 24-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>Feb. 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox, Cumberland, Maryland.</u>						ADDRESS		24a. REC'D BY REGISTRAR <u>Feb. 26, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please give the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for prior to burial, cremation or removal.

Outside of limits

RECEIVED
FEB 28 1957
BUREAU V. 1

BUREAU V. 3

DR. RANSOM

1312

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MORGAN			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 85X-3			
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last POWELL				4. DATE OF DEATH Month FEBRUARY Day 24 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 22, 1957	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GEORGE POWELL				14. MOTHER'S MAIDEN NAME JUANITA M. CORBETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity of Vital Functions 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 22 Feb , 19 57 , to 24 Feb , 19 57 , that I last saw the deceased alive on 23 Feb , 19 57 , and that death occurred at 12:02A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Leland Ransom				ADDRESS (Street, city or town, state) 63 Greene St, Cumberland Md			
DATE SIGNED Feb 24 1957							
PHYSICIAN'S NAME (Type) DR. LELAND RANSOM				ADDRESS 63 Greene St. Cumberland Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Feb. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital				ADDRESS Cumberland Md.		24a. REC'D BY REGISTRAR Feb 25, 1957	
24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

FEB 27 1957

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1313

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY MORGAN ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.				d. STREET ADDRESS 85X-3			
3. NAME OF DECEASED (Type or print) First MRS Middle EMMA Last MAY RAIGNER				4. DATE OF DEATH Month FEB. Day 24 Year 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 11, 1884		9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ELMER RAIGNER			14. MOTHER'S MAIDEN NAME MARGARUTE LADEN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X Stroke DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 72 hrs. (c) 72 hrs.							INTERVAL BETWEEN ONSET AND DEATH 72 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/7/52 , 19____, to 2/24/58 , 19____, that I last saw the deceased alive on 2/24/58 , 19____, and that death occurred at 7:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. J. Williams				ADDRESS (Street, city or town, state) Cumbers, Md			
PHYSICIAN'S NAME (Type) R. J. WILLIAMS				DATE SIGNED 3/24/58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)		
Burial		2/27/58	Camp Hill		Paw Paw, W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Parks Travel Home				ADDRESS Berkeley Springs W. Va.		24a. REC'D BY REGISTRAR DATE Feb 25, 1958	
				24b. REGISTRAR'S SIGNATURE W. R. Krantz, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DATE _____

FEB 27 1957

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BUREAU V. S.

FEB 27 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01337

1314

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 7 DAYS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEAR CUMBERLAND, RURAL, X0				d. STREET ADDRESS BOX 264, RT. #4,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LUCY Middle M. Last RITCHIE				4. DATE OF DEATH Month FEBRUARY Day 26 Year 19 57			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 30, 1882		9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACKSON				14. MOTHER'S MAIDEN NAME Judy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Rt. 4, Middletown Road Jacob F. Ritchie Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arterio Sclerotic 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (Arterio) vasculodis. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2.19.1957 to 2.26.1957 , that I last saw the deceased alive on 2.25.1957 , and that death occurred at 4:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland MD DATE SIGNED 2-26-57			
PHYSICIAN'S NAME (Type) W. F. Williams M.D. Cumberland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery		22d. LOCATION (City, town, or county) (State) Allegany County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR March 2, 1957	
				24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DECEASED ALLEN, Y		MARITAL SINGLE	
DATE OF BIRTH 1910		PLACE OF BIRTH BALTIMORE, MD.	
SEX MALE		RACE WHITE	
OCCUPATION LABORER		PLACE OF DEATH BALTIMORE, MD.	
DATE OF DEATH 1957		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF REGISTRAR J. H. SMITH	
SIGNATURE OF DECEASED ALLEN, Y		SIGNATURE OF WITNESS J. H. SMITH	

BUREAU V. S.

MAR 6 1957

RECEIVED

1315

CERTIFICATE OF DEATH

Reg. Dist. No.

4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 17 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES				e. STREET ADDRESS 38 51 OAK STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First H Middle EILEEN Last ROBINETTE				4. DATE OF DEATH Month FEBRUARY Day 2 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 5, 1919	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months 37 Days 37 Hours 37 Min.		IF UNDER 24 HRS. Months 37 Days 37 Hours 37 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examination Dept.				10b. KIND OF BUSINESS OR INDUSTRY Textile Industry			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME DAVID MC INTOSH				14. MOTHER'S MAIDEN NAME LESSIE A. BUCKLEW			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 220-10-7248			
17. INFORMANT Mr. George E. Robinette, Cumberland, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Ulcerative Colitis 572.2 DUE TO Conditions, if any, which gave rise to immediate case (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Jan 1951 to Feb 2, 1957 , that I last saw the deceased alive on Feb 2, 1957 , and that death occurred at 12:25 P M, from the causes and on the date stated above. ACTUAL SIGNATURE John A. Topper M.D. Hyndman R DATE SIGNED 2.4.57 PHYSICIAN'S NAME (Type) JOHN A. TOPPER 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2-5-1957 22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park 22d. LOCATION (City, town, or county) (State) Cumberland, Md. 23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md. 24a. REC'D BY REGISTRAR DATE 5, 1957 24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.							

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DAVID M. LITZKY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01339

1316

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>20</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>			d. STREET ADDRESS <u>110 GREEN Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>R.</u> Last <u>ROMAN</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>13</u> Year <u>19 57</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-82</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired B & O Railroad, Truck for</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Freight Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Richard Roman</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Miller</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Chart</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u> DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Nov. 19 56</u> , to <u>Feb 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-12</u> , 19 <u>57</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>					
ACTUAL SIGNATURE <u>William R. James</u>		M.D. <u>441 W. Center St.</u> <u>2-13-57</u>			
PHYSICIAN'S NAME (Type) <u>W.P. James</u>		<u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Cumberland Md.</u>		(State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumberland Md.</u>		24a. RECEIVED BY REGISTRAR <u>Feb 13, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>					

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1317

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01340

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2.½ yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 316 Park St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nannie Middle Matilda Last Senn		4. DATE OF DEATH Month Feb. Day 11 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20-1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-Nurses aid.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Flintstone, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas Kifer		14. MOTHER'S MAIDEN NAME Charollete Duble	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Hafer Funeral Home, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO myocardial fibrosis with heart block Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis with hypertention DUE TO several yrs. (c) several yrs.		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Feb. 12-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 14, 1957	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.		24a. REC'D BY REGISTRAR Feb. 13, 1957	
		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1957 FEB 15

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1318 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01341
4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>20 Yrs</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u> d. STREET ADDRESS <u>308 Park St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lottie May</u> Middle <u>Shafer</u> Last <u>Shafer</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>19 57</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 12 -1887</u>			
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Great Capon, W.Va.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Harrison Miller</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Gattrell</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Lueretia Corrick, Cumberland, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Cardio-vascular-renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>also had hypertention</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden over one year</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb. 24-1957</u>				DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John J. Hafer, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>Feb. 26, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Brantley M.D.</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the files prior to burial, cremation, or removal.

1913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MAYLAND WAVE DEPARTMENT OF HEALTH - BALTIMORE 18

01221

BUREAU V. 8

FEB 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01342

1337

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22, Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. STREET ADDRESS 79 Frost Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle R. Last SHANNON	4. DATE OF DEATH Month Feb. Day 25 Year 19 57		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto mechanic		10b. KIND OF BUSINESS OR INDUSTRY Morton's Garage	11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edgar Shannon		14. MOTHER'S MAIDEN NAME Louise Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-01-0692	
17. INFORMANT Mrs. Laura Shannon, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Stenohage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March , 19 56 , to Feb 25 , 19 57 , that I last saw the deceased alive on Feb 25 , 19 57 , and that death occurred at 5:09 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Davis, M.D.		ADDRESS (Street, city or town, state) 2 B Roadway, Frostburg, Md.	
DATE SIGNED 2/27/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-28-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State) Clear Spring Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR 2-28-57	
24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Lee			

CERTIFICATE OF DEATH

1957

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John A. Robinson		Male		35		1922		Baltimore, Md.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Roman Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
March 4, 1957		10:30 AM		Home		Dr. J. H. Smith		St. Mary's Hospital	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Burial Officer	
J. H. Smith		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

MAR 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1338

CERTIFICATE OF DEATH

01343

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 9 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 307 Vine St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jesse Middle James Last Shiflett		4. DATE OF DEATH Month Feb. Day 26 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1888
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elam Shiflett		14. MOTHER'S MAIDEN NAME Flora Halterman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 232-04137A	
17. INFORMANT Mrs. J.J. Shiflett, Westernport, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 4 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1, 1956 to Feb 26, 1957 , that I last saw the deceased alive on Feb 26, 1957 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE P. E. Berry		ADDRESS (Street, city or town, state) Piedmont W. Va.	
PHYSICIAN'S NAME (Type) P. E. BERRY		DATE SIGNED Piedmont W. Va.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 28, 57	
22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Boral		24a. REC'D BY REGISTRAR DATE 3-28-57	
24b. REGISTRAR'S SIGNATURE John C. Kelly			

CERTIFICATE OF DEATH

1932

11343

Page One

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		New York City		New York City		Heart Disease		New York City		10:00 AM		J. Smith		A. Jones	
Occupation		Marital Status		Color		Religion		Education		Previous Illnesses		Manner of Death		Burial Place		Burial Date		Burial Time		Burial Signature	
Teacher		Married		White		Catholic		High School		None		Natural		Catholic Cemetery		Jan 15, 1932		10:00 AM		B. Brown	
Date of Death		Time of Death		Place of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer	
Jan 10, 1932		10:00 AM		New York City		Heart Disease		New York City		10:00 AM		J. Smith		A. Jones		C. Green		C. Green		C. Green	

BUREAU V. B.

JAN 1 1932

RECEIVED

DR. VAN ORMER

1319

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY Pendleton ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS Brushy Run 85X-3			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ALSTON Middle VERNIE Last SHREVE				4. DATE OF DEATH Month FEBRUARY Day 9 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 30, 1895	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING				10b. KIND OF BUSINESS OR INDUSTRY Farm owner		11. BIRTHPLACE (State or foreign country) SMOKE HOLE, W.VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ANDREW BERKELEY SHREVE				14. MOTHER'S MAIDEN NAME JOANNA Shreve			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis with anemia 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis, chronic INTERVAL BETWEEN ONSET AND DEATH 6 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7 Feb., 1957 to 9 Feb., 1957 , that I last saw the deceased alive on 9 Feb., 1957 , and that death occurred at 3:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.				ADDRESS (Street, city or town, state) 122 S. Centre St. Cumberland, Md. DATE SIGNED 9 Feb. 57			
PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12/57		22c. NAME OF CEMETERY OR CREMATORY Shreve Cemetery		22d. LOCATION (City, town, or county) (State) Smoke Hole, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Feb. 12, 1957	
				24b. REGISTRAR'S SIGNATURE W. H. Hantz, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		MALE		WHITE		JAN 5 1928		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
APRIL 4 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY	
10:00 PM		SHOOTING		HOMICIDE		GUNSHOT WOUNDS		GUNSHOT WOUNDS		GUNSHOT WOUNDS		GUNSHOT WOUNDS		GUNSHOT WOUNDS	
PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH	
MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4 1968	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
APRIL 4 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY	
10:00 PM		SHOOTING		HOMICIDE		GUNSHOT WOUNDS		GUNSHOT WOUNDS		GUNSHOT WOUNDS		GUNSHOT WOUNDS		GUNSHOT WOUNDS	

RECEIVED

1967

RECEIVED

1320

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 28 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ISAAC D. Middle SMITH Last SMITH				4. DATE OF DEATH Month FEBRUARY Day 16 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 11, 1890	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer and Owner		10b. KIND OF BUSINESS OR INDUSTRY Insurance Co.	
11. BIRTHPLACE (State or foreign country) W.V.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ISAAC D. SMITH, Sr.				14. MOTHER'S MAIDEN NAME MARY HARPER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) W.W. I		17. INFORMANT Memorial Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 30 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Lat advanced case of Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2-15-1957 to 2-16-1957 , that I last saw the deceased alive on 2-16-1957 , and that death occurred at 2:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W.F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 2/18/57			
PHYSICIAN'S NAME (Type) W. F. WILLIAMS, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Maple Hill Cemtery		22d. LOCATION (City, town, or county) (State) Petersburg, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Blaine Schaffer ADDRESS Petersburg W.V.				24a. REG'D BY REGISTRAR Feb. 18, 1957		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1346

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Catherine A. Stakem				4. DATE OF DEATH Month Day Year February 2 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20, 1874	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work Own Home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ocean, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Daniel Stakem				14. MOTHER'S MAIDEN NAME Bridget Byrne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Annie Campbell Midland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 mo. 6 wks years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 19, 1957 , to Feb 2, 1957 , that I last saw the deceased alive on Feb 2, 1957 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D.				Lonaconing, Md.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/57		22c. NAME OF CEMETERY OR CREMATORY St Michael Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR 4/6/57	
24b. REGISTRAR'S SIGNATURE Jannette M Boal							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

8 14 1957

RECEIVED

1347

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Cumberland, rural.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Cumberland, rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. # 5. Cumberland, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anton</u> Middle <u>Milton</u> Last <u>Struntz</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 20, 1888</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Silk Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. Nat. 9-24-1943</u>	
13. FATHER'S NAME <u>Anton Struntz</u>				14. MOTHER'S MAIDEN NAME <u>Mary Dancer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-6976</u>		17. INFORMANT Address <u>Mrs. Mary Struntz Rt. 5 Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Carcinoma of colon (primary)</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>August 1955</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>August</u> , 1955, to <u>2/3</u> , 1957, that I last saw the deceased alive on <u>2/2</u> , 1957, and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.E. Gattens</u>		M.D. <u>167 E. Main St.</u>		DATE SIGNED <u>2/4/57</u>			
PHYSICIAN'S NAME (Type) <u>W.E. Gattens</u>		<u>Frederick</u>		<u>Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-6-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Ambrose Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cresaptown, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>			ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb. 6, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>W.R. Frank M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

BUREAU V. 1

FEB 8 1957

RECEIVED

1

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01348

1321 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE PENNA		COUNTY SOMERSET	
CITY OR TOWN CUMBERLAND		LENGTH OF STAY DOA		CITY OR TOWN WELLERSBURG			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS 75X-3			
3. NAME OF DECEASED (Type or Print) VICTOR L. STURTZ				4. DATE OF DEATH Feb 27 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED		8. DATE OF BIRTH Aug 14 1912	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS DRIVER		10b. KIND OF BUSINESS OR INDUSTRY BUS Company		11. BIRTHPLACE (State or foreign country) Wellersburg, Pa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William STURTZ				14. MOTHER'S MAIDEN NAME Goldie TROUTMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 168-03-1446		17. INFORMANT & ADDRESS Mrs. Louise STURTZ, Wellersburg, Pa			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
294X IMMEDIATE CAUSE (A) Polycythemia vera						Approx approx	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 1956, to 2-27 1957, that I last saw the deceased alive on 2-27 1957, and that death occurred at 10 A.M. from the causes and on the date stated above.							
SIGNATURE Ethel Topper				M.D. Hyndman		DATE SIGNED 2-28-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF MAR 3 1957		NAME OF CEMETERY OR CREMATORY Cook Cemetery		LOCATION (City, town, or county) Wellersburg, Pa (State)	
24. REC'D BY REGISTRAR March 1, 1957		REGISTRAR'S SIGNATURE Winter R. Frantz, Ms		25. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Zeigler		ADDRESS Hyndman	

CERTIFICATE OF DEATH

FILE NO. 100

DEATH OF DECEASED

DEATH OF DECEASED

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH

DATE OF DEATH
 PLACE OF DEATH
 CAUSE OF DEATH

DEATH CERTIFICATE
 NO. 100

DEATH CERTIFICATE
 NO. 100

DEATH CERTIFICATE
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DEATH CERTIFICATE
 NO. 100

DEATH CERTIFICATE
 NO. 100

BUREAU V. 21

MAR 4 1957

RECEIVED

TO BE COMPLETED BY THE REGISTRAR OF DEATHS
 TO BE COMPLETED BY THE REGISTRAR OF DEATHS
 TO BE COMPLETED BY THE REGISTRAR OF DEATHS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01349

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>		c. LENGTH OF STAY IN 1b <u>61 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Lonaconing</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Irvan</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>May 19-1895</u>		9. AGE (In years last birthday) <u>61 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired machinest helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp</u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Thomas</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Campbell</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Miners Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>422.1</u> DUE TO <u>Cardio-vascular sclerosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb. 3-1957</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Lonaconing</u>		(State) <u>Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u>				ADDRESS <u>Lonaconing, Md.</u>			
24a. REC'D BY REGISTRAR <u>2/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>Janette M. Boul</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1842

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
DISEASE OR INJURY		SYMPTOMS		TREATMENT		POST-MORTEM		OTHER	
SIGNATURE OF EXAMINER		DATE		PLACE		CITY		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION		U. S. DEPARTMENT OF JUSTICE		WASHINGTON, D. C.		RECEIVED	

BUREAU V. 3

7 14 1957

RECEIVED

DR. STEGMAIER

1322

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 27 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ARCHIE HAROLD THOMPSON				4. DATE OF DEATH Month Day Year FEBRUARY 17 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 10, 1898	
9. AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO MECHANIC				10b. KIND OF BUSINESS OR INDUSTRY MARTIN BUICK, KEYSER, W. VA.		11. BIRTHPLACE (State or foreign country) GILMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GOVAN THOMPSON				14. MOTHER'S MAIDEN NAME MARGARET JANE SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 mos 1 yr							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 14 Jan, 1957 , to 17 Feb, 1957 , that I last saw the deceased alive on 16 Feb, 1957 , and that death occurred at 6:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James B. Stegmaier M.D. 132 S. Centre St. Cumberland Md 18 Feb 57							
ACTUAL SIGNATURE DR. JAMES STEGMAIER							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Frostburg, Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, Maryland.				24. REC'D BY REGISTRAR Feb. 18, 1957		24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01351

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 10 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 118 S. Lee St.		d. STREET ADDRESS 118 S. Lee St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alfred Middle S. Last Tingle		4. DATE OF DEATH Month Feb. Day 12 Year 19 57	
5. SEX male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30-1916
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hod Carrier		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Tingle		14. MOTHER'S MAIDEN NAME Ethel Nichols	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 232-26-0826	
17. INFORMANT Memorial Hospital & Welfare Board.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary sclerosis (marked) (c), stating the underlying cause lost. Autopsy findings- T.B. of lungs, adrenals, spleen, liver & lymph nodes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1			
INTERVAL BETWEEN ONSET AND DEATH several yrs			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Feb. 13-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/15/57	
22c. NAME OF CEMETERY OR CREMATORY Alleg. County Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR Feb. 16, 1957	
		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Within corporate limits DR. RANSOM

1324

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND Rural	
c. LENGTH OF STAY IN 1b 2½ HOURS		d. STREET ADDRESS 401 ROBERTS PLACE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last TROUTMAN		4. DATE OF DEATH Month FEBRUARY Day 9 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 9, 1957
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months 2 Days 30	11. IF UNDER 24 HRS. Hours 2 Mins 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALLACE R. TROUTMAN		14. MOTHER'S MAIDEN NAME SARAH LEE STOTTLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Incomplete development of Vital Functions (at 2 1/2 hrs.) 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 Feb 1957 to 9 Feb 1957 , that I last saw the deceased alive on 9 Feb 1957 , and that death occurred at 6:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 638 Breane St Cumberland Md DATE SIGNED 9 Feb 57			
ACTUAL SIGNATURE Leland Ransom		M.D. 638 Breane St Cumberland Md	
PHYSICIAN'S NAME (Type) DR. L. RANSOM			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 2-11-57	22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital	22d. LOCATION (City, town, or county) (State) Cumberland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital		ADDRESS Cumberland Md	
24a. REC'D BY REGISTRAR Feb. 11, 1957		24b. REGISTRAR'S SIGNATURE W.H. Frantz, M.D.	

SEE 11

BUREAU V. S.

FEB 13 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01353

Reg. Dist. No.

4

1325

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 629 Henderson Ave			d. STREET ADDRESS 629 Henderson Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Herman Middle H. Last Twigg			4. DATE OF DEATH Month Feb. Day 24 Year 19 57		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH March 13-1911		9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-track Watchman		10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Riley E. Twigg		14. MOTHER'S MAIDEN NAME Neoma Andrews	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-5969		17. INFORMANT Mrs. Markwood Chaney, Cumberland, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Esophageal hemorrhage due to ulcerated DUE TO (b) Esophageal varicoes & Hemoptysis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Arrested Pulmonary tuberculosis INTERVAL BETWEEN ONSET AND DEATH 8 hrs about 6 Years.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Feb. 24-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 27, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park Cumberland, Maryland	
22d. LOCATION (City, town, or county)		22e. (State)		22f. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland.		ADDRESS		24a. REG'D BY REGISTRAR Feb. 26, 1957	
24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.					

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1321

Form with multiple sections for medical examination and death certification, including fields for name, date, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. 81

FEB 28 1957

RECEIVED

Within corporate limits

1326

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 2/4/57			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle R. Last Willison				4. DATE OF DEATH Month February Day 10 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1885 July 30, 1885	9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Frostburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick E. Rowe				14. MOTHER'S MAIDEN NAME Sarah Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT P.O.Box 599 Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Pulmonary Hypostasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis (c) Cerebral Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 30 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2 Chronic Hypertension							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 2/4/57 , 19____, to 2/10/57 , 19____, that I last saw the deceased alive on 2/10/57 , 19____, and that death occurred at 1:15 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md.						DATE SIGNED 2/11/57	
ACTUAL SIGNATURE James E. McLean M.D.							
PHYSICIAN'S NAME (Type) Dr. James E. McLean				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 12, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland.				24. REC'D BY REGISTRAR Feb. 12, 1957		24b. REGISTRAR'S SIGNATURE W.R. Hantz M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THEORY OF THE

082-208-0

BUREAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01355

1327

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>807 Sephard Dr.</u>				d. STREET ADDRESS <u>1807 Sephard Dr.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Louis Daniel Young</u>				4. DATE OF DEATH <u>Feb. 16, 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 16, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice-Pres. of Laundry Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Henry Young</u>				14. MOTHER'S MAIDEN NAME <u>Margaretta Koegel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-4186</u>		17. INFORMANT <u>Mrs. Louis Young</u> Address <u>807 Sephard Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Hypertensive vascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis with right hemiplegia 12 July 56</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March</u> , 1955, to <u>16 Feb.</u> , 1957, that I last saw the deceased alive on <u>16 Feb. 57</u> , 1957, and that death occurred at <u>8:30</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Alfred Van Ormer</u> M.D. <u>Cumberland, Md.</u>				DATE SIGNED <u>18 Feb 57</u>			
PHYSICIAN'S NAME (Type) <u>W. Alfred Van Ormer, M. D., 122 S. Centre St., Cumberland, Maryland.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 11, 1957</u>		<u>St. Luke's Cem.</u>		<u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md.</u>				24. REC'D BY REGISTRAR <u>Feb. 18, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>	

CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED <i>John Henry Jones</i>		2. SEX <i>Male</i>	
3. AGE <i>65</i>		4. RACE <i>White</i>	
5. DATE OF BIRTH <i>March 15, 1892</i>		6. PLACE OF BIRTH <i>St. Louis, Mo.</i>	
7. OCCUPATION <i>Retired</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DATE OF DEATH <i>February 10, 1957</i>		10. PLACE OF DEATH <i>Home</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Henry Jones</i>		14. SIGNATURE OF WITNESSES <i>John Doe, Jane Smith</i>	
15. SIGNATURE OF FUNERAL HOME <i>John Doe</i>		16. SIGNATURE OF BURIAL PLACE <i>St. Mary's Cemetery</i>	
17. SIGNATURE OF COUNTY CLERK <i>John Doe</i>		18. SIGNATURE OF STATE CLERK <i>John Doe</i>	

BUREAU V. S.

FEB 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

134 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01356

Reg. Dist. No. /

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va. b. COUNTY Ohio			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Old Town, Md.				c. LENGTH OF STAY IN 1b 85X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 51				d. STREET ADDRESS 610 N.Main St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Edward Middle Lewis Last Youngblood				4. DATE OF DEATH Month Feb. Day 10 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 28-1915	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Paw Paw, W.Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward Youngblood				14. MOTHER'S MAIDEN NAME Mary Northcraft			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 235-18-0403		17. INFORMANT Mary N.Youngblood, PawPaw, W.Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination, Intracranial hemorrhage due to fractured skull, right occipital region DUE TO (b) Broken neck, large laceration in front of neck, serving large vessels. DUE TO (c) Auto accident.				INTERVAL BETWEEN ONSET AND DEATH sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Lost control of car, hitting concrete abutment, Rt 51			
20c. TIME OF INJURY Month, Day, Year 11 Feb. 10 1957				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Rt. 51 near Old Town, Allegany, Md.	
20f. (City or town) Highway Rt. 51 near Old Town, Allegany, Md.				20g. (County) Allegany			
20h. (State) Md.							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V.Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED Feb. 11-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 13, 1957		22c. NAME OF CEMETERY OR CREMATORY Camp Hill Cemetery		22d. LOCATION (City, town, or county) (State) Paw Paw, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland.				24a. REC'D BY REGISTRAR Feb. 12, 1957		24b. REGISTRAR'S SIGNATURE Lloyd Luckworthy	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Manner of Death		Place of Death		Date of Death		Time of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
John Doe		45		Male		White		Roman Catholic		Married		Teacher		Heart Disease		Natural		Home		February 15, 1957		10:30 AM		[Signature]		[Signature]		[Signature]	
Place of Birth		Date of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Postmortem Examination		Date of Necropsy		Date of Toxicology Examination		Date of Forensic Examination		Date of Pathology Examination		Date of Radiology Examination	
New York City		January 1, 1912		February 10, 1957		February 12, 1957		February 15, 1957		February 15, 1957		February 15, 1957		February 15, 1957		February 15, 1957		February 15, 1957		February 15, 1957		February 15, 1957		February 15, 1957		February 15, 1957		February 15, 1957	

BUREAU V. 2

FEB 18 1957

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01357

1328

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

W.Va.

b. COUNTY

Ohio

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Wheeling

85X-3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.A. at the Memorial Hospital

d. STREET ADDRESS

610 N. Main St.

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Phyllis

Miller

Youngblood

4. DATE
OF
DEATH

Month

Day

Year

Feb.

10

1957

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

July 22-1917

9. AGE (In years
last birthday)

39

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10b. KIND OF BUSINESS OR INDUSTRY

Singer Sewing Mach.

11. BIRTHPLACE (State or foreign country)

Rowlesburg, W.Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Tye Howard Miller

14. MOTHER'S MAIDEN NAME

Nelle Catherine Kelley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

234-58-0002

17. INFORMANT

Address

Ralph Miller, Rt 4 Cumberland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Intrathoracic hemorrhage due to crushed

823X

DUE TO

chest, fractured left femur, right humerus

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

(b)

right frontal bone, extensive burns, right foot.

DUE TO

Auto accident

(c)

INTERVAL BETWEEN
ONSET AND DEATH

sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Auto hit concrete abutment, Rt. 51-

20c. TIME OF INJURY

Hour

o. m.

Month, Day, Year

11 Feb. 10 1957

20d. INJURY OCCURRED

While

Not while

at work ☐at work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Route 51 near

20f. (City or town)

Old Town Allegany

(County)

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.ACTUAL
SIGNATURE

H.V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒ Feb. 11-1957

DATE SIGNED

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Feb. 13, 1957

22c. NAME OF CEMETERY OR CREMATORY

Camp Hill Cemetery

22d. LOCATION (City, town, or county)

Paw Paw, West Virginia.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Charles L. George, Cumberland, Maryland.

ADDRESS

24a. REC'D BY REGISTRAR

Feb. 12, 1957

24b. REGISTRAR'S SIGNATURE

M.R. Frantz, M.D.

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